

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **6152**  
Registrar's No. **1459**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>1459</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ b. COUNTY <b>ado</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>17</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3647 Blow St. /</b>				d. STREET ADDRESS (If rural, give location) <b>3647 Blow</b>			
3. NAME OF DECEASED (Type or Print) <b>Johanna</b>		a. (First) <b>C.</b>		b. (Middle) <b>Fettig</b>		c. (Last) _____	
4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>13</b> (Year) <b>1949</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>December 10, 1864</b>		9. AGE (In years last birthday) <b>84</b>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 1 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>August Fettig</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Henry H. Lohaus</b> ADDRESS <b>3647 Blow St.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Failure</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio-Sclerosis</b> DUE TO (c) <b>Senility</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <b>97</b> <b>H221</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2 yrs.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>2/7/49</b> , 19____, to <b>2/14/49</b> , 19____, that I last saw the deceased alive on <b>2/13/49</b> , 19____, and that death occurred at <b>10 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Benjamin P. Lohaus</b> (Sign or title)				23b. ADDRESS <b>7430 Virginia Avenue</b>		23c. DATE SIGNED <b>2/14/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Feb. 16, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus emetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>FEB 15 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>C. Hoffmeister</b> ADDRESS <b>U. &amp; L. Co. 7814 S. Broadway</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....

Student Embalmer

Licensed Embalmer No. 2679

P. O. Address 7814 T. Broadway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.